EXCEL ORTHODONTICS

Dr. Paul Hwang D.D.S., M.S.

PATIENT HEALTH QUESTIONNAIRE FOR:_____ **D.O.B** _____

Please complete both pages of this health questionnaire as fully and completely as possible, writing in any other information you feel would be helpful. Your confidentiality will be respected.

Have you been evaluated by another Orthodontist?_____

Emergency Contact (Full Name & Phone Number):_____

ADDRESS:_____

_____

Phone #:_____

Email:_____

Insured's Name:_____

Insured's Date of Birth:_____

Insured's S.S.#:_____

Insured's Employer:_____

Dental Insurance Co.:_____

__ Crowded teeth
__ "Buck teeth"
__ Prominent jaw
__ Spacing between teeth
__ Missing teeth
__ Mouth too small
__ Irregular teeth
__ Ears Ring/Stuffy
__ Neck pain
__ Irregular facial appearance
__ Over bite
__ Receded jaw
__ Gummy smile
__ Gum disease/recession
__ Jaw dysfunction
__ Clicking jaw joint
__ Protrusion of teeth
__ Headache/Face pain
__ Jaw pain
__ Other: _____

FAMILY MEMBERS WITH SIMILAR CONDITION:

- Father _ Mother _ Brother _ Sister
- Other: _____

PATIENT'S CURRENT PHYSICAL HEALTH:

☐ Excellent _ Good
☐ Fair _ Poor

KNOWN OR SUSPECTED ALLERGIES:

☐ Antibiotics: _____
☐ Pain pills: _____
☐ Foods: _____
☐ Environmental allergies: _____
☐ None

_____ PLEASE INITIAL

CONDITIONS THE PATIENT HAS OR HAS HAD:

☐ AIDS
☐ Allergies
☐ Asthma
☐ Autoimmune disorders
☐ Blood disease
☐ High blood pressure
☐ Low blood pressure
☐ Bone disorders
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Eating disorders
☐ Endocrine problems
☐ Emotional problems
☐ Female problems
☐ HIV positive status
☐ Hepatitis
☐ Heart disease
☐ Heart murmur
☐ Hearing disorder
☐ Kidney disease
☐ Rheumatic fever
☐ Ringing of the ears
☐ Sleep disturbance
☐ History of trauma
☐ _ Teeth _ Face _ Jaws _ Head
☐ None of the Above

_____ PLEASE INITIAL

CURRENT MEDICATIONS:

☐ Heart pills
☐ Antibiotics: _____
☐ Diet pills: _____
☐ Pain pills: _____
☐ Vitamins: _____
☐ Birth control pills: _____
☐ Muscle relaxants: _____
☐ Insulin: _____
☐ Other: _____
☐ None

_____ PLEASE INITIAL

HAS (CHILD) PATIENT REACHED PUBERTY:

- Yes, approximate date: _____
- No

PRIMARY BREATHING PATTERN:

- ☐ Mouth _ Nose
- ☐ Depends on _____

DOES THE PATIENT SNORE WHEN SLEEPING?

- ☐ Yes _ No
- ☐ Sometimes: _____

DIFFICULTY CHEWING?

If yes, please indicate below which apply:

- Teeth don't meet well
- Pain when chewing
- Other: _____
- No

CHECK ALL THAT APPLY:

- ☐ Frequent sore throat/tonsillitis
- ☐ Speech problems
- ☐ Pain in the RIGHT jaw joint
- ☐ Pain in the LEFT jaw joint
- ☐ Clicking/popping in RIGHT jaw joint
- ☐ Clicking/popping in LEFT jaw joint
- ☐ Current thumb/finger sucking habit
- ☐ Previous thumb/finger sucking habit
- ☐ Lip biting/sucking habit
- ☐ Grind teeth
- ☐ Clench jaws
- ☐ Tongue thrust when swallowing

FREQUENCY OF DENTAL CHECKUPS?

- ☐ Once per year
- ☐ Twice per year
- ☐ More than twice a year
- ☐ Emergencies only
- ☐ Never

PATIENT'S INTEREST IN ORTHODONTIC TREATMENT?

- ☐ Wants treatment
- ☐ Only if necessary
- ☐ Unwilling
- ☐ But will cooperate if treatment is needed
- ☐ Uncooperative

ORTHODONTIC EXAM PROMPTED BY:

- ☐ Patient _ Mother _ Spouse
- ☐ Dentist _ Father _ Sibling
- ☐ Doctor _ Friend _ Other

MEDICAL, DENTAL, OR SURGICAL PROBLEMS NOT COVERED ON THIS FORM?

- Yes, please describe: _____

_____

_____

_____

_____

_____ _____ _____

Responsible Party Signature Printed Name Date

_____ _____ _____

Reviewed By Doctor Printed Name Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. Obtain payment from third-party payers.
Conduct normal health & dental care operations such as quality assessments and physicians certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices.* From time to time and that I may contact Dental Health Associates at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. In addition, I understand you are not required to agree to my requested restrictions.

PATIENT NAME (PRINT) _____

SIGNATURE _____

RELATIONSHIP TO PATIENT _____

DATE_____

(Office use only)

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT OF THE *NOTICE OF PRIVACY PRACTICES,* BUT WAS UNABLE TO DO SO AS DESCRIBED BELOW:

DATE_____ INITIALS_____

REASON_____